Correspondence

The Editors will be pleased to receive and consider for publication correspondence containing information of interest to physicians or commenting on issues of the day. Letters ordinarily should not exceed 600 words and must be typewritten, double-spaced, and submitted in duplicate (the original typescript and one copy). Authors will be given the opportunity to review the editing of their correspondence before publication.

Doctors, Patients, and Fear

To THE EDITOR: I find it quite incredible that an article like "Doctors, Patients, and Fear" by A. M. Levine, MD, which appeared in the June issue,[1] could be published in a scientific journal in 1989. I do not feel that any physician would argue with the general message that fear, lack of educating the patient, and not taking time to talk to the patient substantially interfere with a patient's ability to make a reasonable decision as to choice of treatment.

I do find this physician's conclusions, "apparently, when his mind was at ease, as opposed to stressed and frightened, some chemical or immunologic event must have occurred, which apparently had a positive effect on his malignant lymphoma," to be less than conclusive.

I would think that alternative conclusions, the most obvious of which would be an error in measurement and clinical assessment of organ size, would rate somewhat higher.

I do not discount the physician's "conclusion" but feel that, in this day and age of "cancer quackery," we as physicians in the scientific community should be a little more careful in our wording and interpretation of data. The art of medicine does not need to exclude scientific methodology.

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REFERENCE

1. Levine AM: Doctors, patients, and fear. West J Med 1989; 150:723

Psychiatric Manifestations of Physical Illness

To THE EDITOR: Many medical illnesses cause dysfunction in mood, thinking, and behavior and may present as depression or mania, anxiety disorders, paranoid disorders, schizophreniform disorders, or confusional states. Many patients diagnosed as having a mental disorder in fact have a physical disorder that is causing the psychiatric manifestations. Many more physical disorders cause psychiatric symptoms than was thought to be the case in the previous decade. Psychiatrists are more likely than nonpsychiatric physicians to overlook an underlying physical disorder. Nonpsychiatric physicians more frequently treat psychiatric symptoms as coincidental to, rather than as caused by, underlying physical disorders.

Eight major categories of physical illnesses are most likely to be associated with psychiatric symptoms: (1) toxic states, especially those due to alcohol, marijuana, cocaine, and benzodiazepine toxicity or withdrawal; (2) carcinoma, especially pancreatic carcinoma; (3) pulmonary diseases, especially chronic obstructive pulmonary disease and asthma; (4) cardiovascular disease, especially coronary artery disease and congestive heart failure; (5) blood dyscrasias, particularly anemia; (6) infectious disorders, particularly the acquired immunodeficiency syndrome, hepatitis, sexually transmitted diseases, mononucleosis, and influenza; (7) cerebrovascular disorders, including seizure disorders, demyelinating neurologic disorders, and encephalopathies; and (8) endocrine diseases, especially hyperthyroidism, hypothyroidism, and diabetes.

In a review of 99 patients with a diagnosis of "hysteria" observed for seven to nine years, 4 patients committed suicide, 8 died of disorders that must have been present at the time of the original diagnosis, and 22 were suffering from a major organic illness—including cholecystitis, meningitis, or Alzheimer's disease—all undiagnosed at the time. Eleven patients had schizophrenia or major depression. Out of the original group, only 20 were accurately diagnosed and 69 were inaccurately diagnosed and presumably mismanaged.[1]

More than 2,000 patients in a psychiatric clinic were studied, and 43% were found to have significant medical illness. Half of those had been undiagnosed by the referring physician. Of this group, 18% had psychiatric symptoms that were caused by the underlying physical disorder, 51% had a physical illness that existed before the psychiatric diagnosis, and in 31% the psychiatric disorder and the medical disorder were coexistent.[2]

Thus, the underdiagnosing of underlying physical illness is the rule and not the exception in patients with mental disorders.

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REFERENCES

1. Slater E: Diagnosis of 'hysteria.' Br Med J 1965; 1:1395-1399
2. Koranyi EK: Morbidity and rate of undiagnosed physical illness in a psychiatric clinic population. Arch Gen Psychiatry 1979; 36:414-419

More on Foot Punctures

To THE EDITOR: Most of us are now aware of the association of puncture wounds to the foot through tennis shoes and pseudomonas infections. The article by Patzakis and colleagues in the May issue[1] confirms our impression of the potential dangers with such wounds.

The authors did not explain, however, what they mean by "earlier definitive treatment" to "decrease morbidity." They also mentioned that, "hospital admission at the time of the initial medical evaluation" should be considered for certain types of wounds.

I would like a further explanation of what the definitive therapy is and why a person must be admitted to hospital.

I have begun seeing all such patients in the office and attempting to debride the puncture wounds under local anesthetic. I often find small pieces of material (presumed to be part of the tennis shoe) in the puncture wound. Although my